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| A 088 | 482.13(f)(3)(v) SAFE RESTRAINING TECHNIQUES<br><br>The use of a restraint or seclusion must be in accordance with safe and appropriate restraining techniques.<br><br>This STANDARD is not met as evidenced by:<br>Based on record reviews, staff interviews, and review of policy and procedures, the hospital failed to use safe and appropriate restraint techniques for 1 of 1 patient sampled (patient #2).<br><br>Findings include:<br><br>Medical record review conducted on 8-10-06 revealed patient #2, a 48-year-old male admitted on 5-24-06 to U2/3East with a diagnosis of Paranoid Schizophrenia. Patient #2 is a current patient in the hospital.<br><br>Medical record review conducted on 8-10-06, 8-15-06, and 8-17-06 revealed progress notes for patient #2. Progress notes dated from 5-24-06 to 5-28-06 revealed no documentation for complaints of pain or discomfort from patient #2. Patient #2 was checked periodically due to active psychosis, not pain. Per progress note on 5-29-06 at 7:50 pm, patient #2 was restrained by staff #6 and staff #10 for one minute for entering the nursing station and refusing to leave. Per documentation, patient #2 refused redirection, locked himself in the room with staff, and became verbally and physically aggressive. Restrictive Intervention Progress Note dated 5-29-06, documented the reason and use of the therapeutic intervention. Restrictive Intervention Progress Note indicated patient #2 was placed in restrictive interventions due to "attacking staff and refusing to cooperate with staff". Patient #2 was | A 088 | | 9/15/06 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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released from the Nonviolent Crisis Intervention (NCI) hold due to "verbalization of control". Restrictive Intervention Progress Note indicated all vital signs were taken and no discomfort was reported by patient #2 or noticed by staff #13 completing the assessment. Patient #2 was assessed by the staff #9 with "no injuries" at 7:40 pm. RN completing Restrictive Intervention Progress Note records all times in "am" while MD records time in "pm". Progress note dated 5-30-06 at 10:15 am by staff #11 indicated patient #2 had "difficulty standing or ambulating". Patient #2 complained of pain to leg. MD was notified and patient #2 was sent to the local emergency room for evaluation and treatment. Progress note dated 6-21-06 at 6:50 pm indicated patient #2 was admitted to Psych. Med. Unit after "left tibial plateau fracture with repair and open reduction". Reviewed of medical record for patient #2 revealed Physician's Orders for NCI hold (dated 5-29-06) and transfer to local emergency room for evaluation (dated 5-30-06).

Review of facility's internal investigation revealed medical record reviews, interviews, and written statements from all staff involved in the incident with patient #2:

Administrative Investigation Report dated 7-13-06 included a review of chart for patient #2 from the local hospital. Per review of the report, x-ray report for patient #2 dated 5-30-06 revealed "a severely comminuted fracture of the tibial plateau with at least three major fragments and possibly more" with some "subluxation of the femur to the medial side of the tibia".

Administrative Investigation Report dated 7-13-06 for patient #2 revealed interviews and statements

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from staff. Per statement of staff #6, patient #2 entered nursing station and used his body to barricade the door. Patient #2 refused redirection and became physically aggressive towards staff present in the station (staff #6, staff #10, staff #15, and staff #13). Staff #6 initiated a NCI hold with staff #10. Staff #13 "called male help to 3-East stat". Staff #6 released patient #2 from the NCI hold, because calmness was verbalized. Per staff #6 an unknown number of male help arrived to assist with patient #2. Staff #6 reported being "pushed back and out of the area of the incident". Staff #6 reported the first NCI hold was over and the responding male staff placed patient #2 in another NCI hold. Staff #6 reported no communication between present staff and responding male staff during the NCI hold.

Administrative Investigation Report dated 7-13-06 for patient #2 revealed interviews and statements from staff. Per statement of staff #10, patient #2 "slid in behind me" as staff #10 entering the nursing station. Patient #2 was asked to leave the nursing station about three times and did not leave. Patient #2 was "swinging wildly at us". Per interview, staff #10 and staff #6 initiated a NCI hold and put patient #2 on the ground for one minute. Staff #13 called for assistance. Per staff #10, patient #2 was getting up from the NCI hold when the male respondents arrived. Staff #10 reported "I was pushed over by the computer", and "they piled on him". Staff #10 reported no communication between present staff and responding male staff during the NCI hold.

Administrative Investigation Report dated 7-13-06 for patient #2 revealed interviews and statements from staff. Per statement of staff #13, patient #2 entered when staff #6 and staff #10 entered the

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nursing station. Patient #2 refused redirection and locked himself in the nursing station with the staff present. Per staff #13, staff #6 and staff #10 "grabbed the patient arms and placed him in a hold". Per statement from staff #13, "patient was brought down to the floor and held against the wall". By the time the male respondents arrived, staff #6 and staff #10 had patient #2 under control. Staff #13 reported no communication between present staff and responding male staff during the NCI hold.

Administrative Investigation Report dated 7-13-06 for patient #2 revealed interviews and statements from staff. Per statement of staff #15, patient #2 entered the nursing station and staff #6 and staff #10 entered behind patient #2. All staff present (staff #6, #10, #13, and #15) attempted to redirect patient #2 from the nursing station. Staff #6 and staff #10 initiated the NCI hold when patient #2 began walking towards staff #13 and staff #15. Staff #13 had "overhead paged for male help". Male help arrived after patient #2 was calm and moving towards the restraint room. Staff #15 reported no communication between present staff and responding male staff during the NCI hold.

Administrative Investigation Report dated 7-13-06 for patient #2 revealed interviews and statements from staff. Statements from staff #5, #7, #8, #12, #14, #16, #17, #18, #19, and #20 reported no contact with patient #2 during the NCI hold.

Administrative Investigation Report dated 7-13-06 for patient #2 revealed interviews and statements from staff. Per statement of staff #11, patient #2 was observed sitting in a chair outside the nursing station in no acute distress. Patient #2 lifted himself from a chair with no assistance, but later

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fell to the floor when trying to walk. Staff #11 examined the legs first, due to the nature of the fall. The left leg appeared to be swollen and tight at the knee. The medical doctor was called two times. Patient #2 was transported to the local emergency room for follow-up evaluation and treatment. Per statement, patient #2 had no complaints of pain noted prior to incident.

Staff interviews were conducted on 8-15-06 and 8-17-06. Interview with staff #13 supported information of written statement. Per staff #13, patient #2 entered the nursing station and refused redirection. Staff #6 and staff #10 initiated an NCI hold while male assistance was called. Male help arrived after the NCI hold was over and patient #2 was getting up from the floor. Staff #13 reported no RN assessment was done, only the restrictive intervention documentation. Staff #13 reported no communication between the present staff and the male respondents during the NCI hold.

Staff interviews were conducted on 8-15-06 and 8-17-06. Interview with staff #10 supported information of written statement. Per staff #10, the NCI hold was over when the male help arrived. Staff #10 reported being knocked out the way and the male help took over. Staff #10 reported no communication between the present staff and the male respondents during the NCI hold.

Staff interviews were conducted on 8-15-06 and 8-17-06. Interview with staff #6 supported information of written statement. Per staff #6, a therapeutic intervention was used on patient #2. Staff #13 called for available male help to assist. Patient #2 started fighting again when all the male help arrived. Per staff #6 about thirteen people

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| A 088 | Continued From page 5<br>arrived to assist. Staff #6 was pushed into a corner. Staff #6 reported no communication between the present staff and the male respondents during the NCI hold.<br><br>Review of policy and procedures and NCI manual on 8-10-06, 8-14-06, and 8-17-06 revealed the standards for restrictive interventions. Interviews were conducted on 8-17-06 with staff #21 and staff #22. Both staff reported initial training was provided, and refresher training was required. If a staff person failed the required test, then the staff was re-trained or paired one-on-one with a NCI trainer. Interviews revealed all facility-trained staff received training on the "2-man carry". Staff #21 and staff #22 also reported "therapeutic communication" is an important part of a restrictive intervention. Both staff confirmed the staff involved in the initial NCI hold should assume the lead, if a request was made for additional assistance. Staffs #6, # 10, #17, #19, and #20 all had current trainings for NCI. | A 088 | | |
| A 254 | 482.25(b)(2) LOCKED STORAGE AREA<br><br>Drugs and biologicals must be kept in a locked storage area.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review, observations, and staff interviews, the hospital failed to ensure medications were secured in a locked area at all times for 1 of 1 patient sampled (patient #3) with a delayed discharge.<br><br>Findings include:<br><br>Medical record review conducted on 8-10-06 revealed patient #3, a 32-year-old male, was | A 254 | | 9/15/06 |

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admitted to U2/3 West on 7-15-06 with the diagnoses of Bipolar II D/O (Disorder) by history, R/O (Rule Out) Impulse Control D/O, and Polysubstance Dependency in Remission.

On 8-10-06 the hospital document "A Framework for A Root Cause Analysis and Action Plan in Response to a Sentinel Event" was reviewed. The document revealed on 7-20-06 at 11:37am patient #3 was notified he would be discharged from Cherry Hospital and was scheduled to leave on the 12:30pm bus. According to the document patient #3's discharge medications were given to him, which he placed in his personal belongings bag. A HCT (healthcare technician) accompanied patient #3 downstairs to the lobby to meet a Cherry Hospital Police officer (to take patient #3 to the bus station). However, patient #3, the HCT, and the police officer were notified that patient #3 would miss the 12:30pm bus. According to the document, patient #3 was re-scheduled to take the 4:00pm bus. Patient #3 and the HCT returned to U2/3 West, where his personal belongings bag (with medications inside) was placed in a locked closet. Further review of the document revealed at the 3:00pm change of shift, patient #3 asked a HCT for his bag so he could change clothes. The document indicated the HCT was unaware patient #3's bag contained medications, and gave the bag to him. According to the document patient #3 returned the bag to staff approximately 2 minutes later. The document stated "Within 5 minutes, another patient relayed to nursing staff that the patient (patient #3) told him that he had taken 28 Elavil 50 mg (milligrams) tablets (part of his discharge meds)." According to the document nursing staff confirmed the Elavil bottle was empty. The document revealed patient #3 was evaluated by

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medical staff, Poison Control was notified, and he was transferred to an acute care hospital by EMS at approximately 4:00pm on 7-20-06.

Nursing progress notes on 7-16-06, 7-17-06 (x2), and 7-18-06 indicated patient #3 denied suicidal ideation (SI). Documentation by a physician on 7-20-06 also revealed patient #3 denied SI.

Review of patient #3 s medical record revealed a social work progress note, dated 7-20-06 at 11:37am. The social worker documented patient #3 became "agitated" and "angry" after he found out he would be discharged. According to the progress note, patient #3 "cussed out staff and stated 'I'm not leaving this F***ing hospital'." The social worker documented "Pt (patient) is lying and manipulating as best as he can @ this time due to not wanting to leave hospital. Pt is angry but does not meet criteria for continued stay @ hospital and will be discharged today."

Further review of patient #3's medical record revealed a nursing progress note, dated 7-20-06 at 12:35pm, which indicated patient #3 missed the 12:30pm bus. According to the note, patient #3 was "reluctant" to leave and "initially refused to leave." The nurse documented patient #3 was re-scheduled to catch the bus at 4:45pm.

A nursing progress note, dated 7-20-06 at 4:30pm, revealed at approximately 3:15pm patient #3 asked a HCT for his bag, which had been placed in a locked closet due to his delayed discharge. The nurse documented a HCT gave patient #3 his bag, which he kept for about 2 minutes and returned to the HCT. The progress note revealed "Patient then stated to another peer that he took all of his Elavil (50mg tabs,

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#28). Patient states he took the pills because he didn't want to leave and wants to die." According to the note the PA immediately responded, patient #3's vital signs were stable, he remained alert and oriented, he was placed on CO 1:1 (constant observation), and EMS arrived at 4:00pm.

Further review of patient #3's medical record revealed a PA progress note, dated 7-20-06 at 3:30pm. The PA documented Poison Control was called and the case was discussed with the medical physician and with the physician in the ER (emergency room) at the acute care hospital. The note revealed the plan was to send patient #3 to the acute care hospital via ambulance.

A nursing progress note, dated 7-20-06 at 4:05pm, stated "Being sent to ED (emergency department) @ this time ... "

Another nursing progress note, dated 7-20-06 at 6:05pm, revealed patient #3 was admitted to the acute care hospital, was sent to the ICU (intensive care unit), and was on a ventilator.

On 8-15-06 the hospital document "Administrative Investigation Report - Guidelines", completed by a nurse manager on 7-20-06, was reviewed. The investigation included statements from staff regarding patient #3's overdose of Elavil on 7-20-06. Review of staff #1's (Registered Nurse) statement revealed patient #3 was being "uncooperative with discharge process" and would get "angry and start cursing when discharge was mentioned." Staff #1 reported patient #3 stated he took the Elavil "because he did not want to leave." The statement revealed patient #3 voiced no suicidal

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| A 254 | Continued From page 9<br>ideation during the day.<br><br>Staff #2's (Registered Nurse) statement revealed he was at the nurses' station when a patient came in and reported patient #3 was telling other patients that he took an overdose of pills. Staff #2 ' s statement patient #3 asked for his bag (which was locked in a closet) around shift change so he could change clothes before he was discharged. Staff #2's statement revealed the HCT who gave patient #3 his bag was not aware that it contained medications. According to the statement patient #3 stated "I told Yall I did not want to leave."<br><br>Staff #3's (HCT) statement revealed he brought patient #3 back to U2/3 West after missing the 12:20pm bus. According to the statement "I locked the patient's bag up. I was unaware that there were any medications in the bag." On 8-15-06 staff #3 confirmed his statement in interview. Staff #3 reported, since the incident, staff was "trying to be extra careful."<br><br>Staff #4's (HCT) statement revealed patient #3 asked him to give him his belongings bag so he could get a pair of shorts. After patient #3 was finished with the bag, staff #4 returned it to the closet. According to the statement another patient stated 'Hey, that guy (patient #3) just took a bottle of medicine. "<br><br>Further review of the investigation documents revealed the Conclusions section, which stated "Patient (#3) was upset because he did not want to be discharged. While there were some important issued discovered during this investigation we are unable to substantiate neglect." | A 254 | | |

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| A 254 | Continued From page 10<br><br>On 8-15-06 a tour of U2/3 West was conducted. Observations revealed the supply closet where patient #3's personal belongings bag (with medications inside) was stored on 7-20-06 upon his return to the ward after he missed the bus. Observations also revealed the medication room, which staff from 3 West and 3 East share. The door to the medication room was propped open, with nursing staff inside preparing medication. Observation revealed a medication cabinet immediately on the left after entering through the door to the medication room. Per nursing staff the medication cabinet was used for storage of discharge medications. Observations revealed the lock to the medication cabinet was broken with discharge medications stored inside. Nursing staff confirmed the lock on the medication cabinet was broken and had been broken for an unknown period of time.<br><br>Review of page 3 of the hospital document, "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event" , confirmed patient #3's medications were not properly secured after his discharge was delayed. The document stated "The medications were not removed from his personal bag and locked in the medication cabinet when his discharge was delayed."<br><br>On 8-15-06 a directive to all nursing staff regarding delayed discharges, dated 8-11-06, was reviewed. The directive was "effective immediately" and instructed staff not to give discharge medications to patients until he/she is picked up. The directive stated "All medications will be maintained in a secured medication room and/or the locked pharmacy delivery cabinet in | A 254 | | |

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each unit. This should prevent patients from having any medications on them until they are ready to depart the building."

Further review of the document, "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event", revealed patient #3 remained at the acute care hospital after the overdose of Elavil (7-20-06) until 7-22-06 at 5:30pm, at which time he returned to Cherry Hospital. The document revealed a PA (physician assistant) examined patient #3 on 7-22-06 at 7:45pm and he had a "raspy cough and temperature (100.6)." The document revealed over the next 3 days, patient #3 had "respiratory symptoms" which were addressed by medical assessment, labs, x-rays, and medication. Further review of the document revealed on 7-26-06 at 3:00am, patient #3 was "unresponsive" and "absent of pulse and respirations." According to the document, a code blue was called, CPR was started, and patient #3 was transferred to an acute care hospital. The document indicated patient #3 was then transferred to another acute care hospital where he died at 5:30pm.

Further review of patient #3's medical record revealed a nursing progress note, dated 7-26-06 at 3:15am, which stated "Requested to check pt (patient) per staff, upon entering room, is noted to be unresponsive to verbal/tactile stimuli, skin warm and moist, unable to palpate radial/carotid pulse, or auscultate apical pulse; code blue (3370) called and CPR initiated."

Further review of patient #3's medical record revealed a physician progress note, dated 7-26-06 at 6:00am. The physician documented

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 344003 | A. BUILDING _____ B. WING _____ | C 08/15/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHERRY HOSPITAL | 201 STEVENS MILL ROAD GOLDSBORO, NC 27530 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| A 254 | Continued From page 12<br>"Responded to Code Blue at 3:10AM. Pt (patient) on floor (with) no V.S. (vital signs), CPR in progress, continued CPR till EMS arrived 3:30AM...pt transferred to (name of acute care hospital) per ambulance for further management."<br><br>Further review of patient #3's medical record revealed the Report of Death to DHHS - Division of Facility Services, which indicated patient #3 died at an acute care hospital on 7-26-06. The immediate cause of death was documented as "possible arrhythmia" due to or as a consequence of "elavil overdose." | A 254 | | |